STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from August 15, 2011 through August 24, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 203. The stage 2 sample was 47 residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	**Immediate Corrective Action** **F157** Resident sent to the hospital for an unrelated medical condition. **Identifying other residents having the potential to be affected** All residents that are care planned for elopement risks have the potential to be affected by this practice. **Systemic Response** Director Of Nursing (DON) reviewed P/P #1405 (Hypoglycemia Protocol) and found protocol was followed. Then DON and Certified Diabetes Educator (CDE) reviewed the policy on 9/14/11 and updated the Hypoglycemia Protocol. The policy was revised on 9/22/11 to ensure physician notification is done for any Finger Stick Blood Sugar (FSBS) < 70 via doctor's communication book. (See Attached Policy) Nursing staff will be inserviced on this policy change by 10/8/11.	5/8/11 9/22/11 10/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director | (X6) DATE: 9/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R29) out of 47 residents sampled the facility failed to consult with the physician when there was a change in a resident's condition. R29 had a finger stick blood sugar (FSBS) of 28 mg/dL (milligrams per deciliter) and the facility failed to consult R29's physician. Findings include: R29 was admitted to the facility on 4/14/11 with diagnoses including status post right below the knee amputation, status post cholecystectomy, insulin dependent diabetes mellitus, hypertension, chronic obstructive pulmonary disease, hypertension, stage IV pressure ulcer (PU) of sacrum, and end stage renal disease (ESRD). Review of R29's "Physician's Order Sheet for Hypoglycemia Protocol" signed on 4/14/11 stated the following: 1. Obtain FSBS. 2. Treat: < (less than) 50 mg/dL with 2 tubes of glucose gel (30 gms CHO, or 30 grams of carbohydrates). 3. Observe resident for 15 minutes after the treatment is given and recheck FSBS. A. < or equal to 70 mg/dL: Repeat treatment. May repeat treatment X2. Alert: Notify the physician immediately if FSBS <	F 157	**Monitoring** Supervisor to perform random audits (from information obtained from 24-hour report) for any FSBS <70. If the documentation shows that the physician was not notified the supervisor will forward the information to the CDE for individual staff re-education. Audits will be forwarded to Quality Assurance on a monthly basis.	10/8/11 and ongoing

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F 157	Continued From page 2 or equal to 70 mg/dL after third treatment. Continue to retreat and recheck until new orders obtained. Review of Nurse's Note (N.N.) dated 5/8/11 timed 9 AM documented that at 7:30 AM, R29's FSBS was 28 and the hypoglycemic protocol was initiated. The FSBS at 7:50 AM after the administration of two tubes of glucose gel was 48 mg/dL. R29 was administered two additional tubes of glucose gel and recheck of the FSBS at 8:10 AM was 72. R29 was fed by staff, however, only consumed the applesauce and was given 1 can of Glucerna. An interview with E29 (Medical Director) on 8/24/11 at approximately 3 PM confirmed that the physician should have been notified of the FSBS of 28mg/dL. An additional interview with E27 (attending physician) on 8/29/11 at approximately 3 PM confirmed that the physician should have been notified of the FSBS of 28mg/dL.	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164	**Immediate Corrective Action** **F164** E-mail memo sent out by the DON on 9/14/11 as a reminder of the importance of maintaining the resident's privacy. (See Attached Memo) **Identifying other residents having the potential to be affected** Any resident receiving care has the potential to be affected by this practice.	9/14/11

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F 164	Continued From page 3 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that nine (R158, R126, R161, R14, R43, R90, R30, R31, and R76) residents were not provided personal privacy during personal care or toilet use. Findings include: The facility's policy and procedure for Bathing stated "Policy: 2. The privacy and dignity of the resident must be maintained throughout the bath or shower. A sheet or blanket should be used to prevent chilling, as well as exposure. Doors should be closed. Curtain should be pulled all around the bed..." 1. During the initial tour of the Prickett building on 8/15/11 the following residents were observed in their rooms in their beds uncovered with a diaper on being bathed by staff. The curtains were not	F 164	**Systemic Response** **Concerns #1 and #2** DON or designee will meet with the individual employees to re-educate them on the importance of maintaining the resident's privacy and dignity. Supervisors and head nurses will do random privacy rounds and issues will be addressed immediately with any employee found to be deficient with providing privacy. **Concerns #3, #4 and #5** Policies #1718 (Insulin Administration), #1400 (FSBS: Tracking, Obtaining and Testing Blood for Glucose) and #1713 (Medication Administration via Nasogastric, Gastrostomy or PEG tube) will be reviewed and revised to emphasize the need for privacy when performing finger sticks, giving insulin and administering meds via enteral tube, etc. (See Attached Policies) Nursing staff will be inserviced on these policy highlights by 10/8/11. **Monitoring** Random audits will be reviewed by the supervisors and head nurses. Staff to be re-educated immediately if deficient practice is found. Random audits will also be performed and reviewed by QA to determine if re-education and/or discipline is appropriate and refer this information to the DON.	10/8/11 and ongoing 9/22/11 10/8/11 10/8/11 and ongoing

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F 164	Continued From page 4 drawn completely around these residents allowing other residents and anyone entering the room to observe them getting a bath. a. R158 was observed being bathed by E11 (CNA) at 9:25 AM b. R126 was observed being bathed by E12 (CNA) at 9:30 AM c. R161 was observed being bathed by E13 (CNA) at 9:35 AM d. R14 was observed being bathed by E14 (CNA) at 9:40 AM 2. On 8/22/11 at approximately 9:30 AM, R43 was observed in her room that she shared with three other residents in bed being bathed by E15 (CNA). The curtain was not pulled around the head of her bed. R43 had a diaper on and was not covered. R43 immediately began grabbing clothes lying on the bed to cover herself. E15 stated she (surveyor) is not here to talk to you she is over there with the other resident. E15 still did not pull the curtain around R43's bed for privacy during this bath. 3. During medication observation on 8/18/11 at approximately 11:30 AM, E31 (Licensed Practical Nurse/LPN) failed to provide personal privacy prior to puncturing R90's finger to obtain blood for testing. 4. During medication observation on 8/16/11 at 9:25 AM, , E33 (Registered Nurse/RN) administered subcutaneous injection to R30's right upper arm while R30 was in the hallway, thus, failing to provide personal privacy. 5. During medication observation on 8/18/11 at	F 164		

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F 164	Continued From page 5 approximately 3:25 PM, E35 (RN) administered medication through R31's percutaneous endoscopic gastrostomy and failed to provide personal privacy. 6. During medication observation on 8/16/11 at approximately 11:42 AM, E36 (LPN) failed to provide privacy prior to puncturing R76's finger to obtain blood for testing.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225 **Immediate Corrective Action**	**F225** **Concern #1** This allegation of abuse was investigated by Quality Assurance for R116 and our investigative findings and summary were reported to DLTCRP Investigative Unit on 9/7/11. Staff members that did not report our resident's allegation of abuse will be addressed individually by their supervisor(s). Supervisor(s) will schedule counseling sessions with their employees to remind them about their responsibility and adherence to abuse reporting laws and our PM-46 requirements. **Concern #2** On 8/18/11, Quality Assurance received an incident report for R110 and our resident stated that there was a basket on top of a television and inside the basket were several envelopes. Inside an envelope was $10.00. Regarding this incident, financial management was contacted by Quality Assurance and they stated that $10.00 was received by our resident in June and no more since. This was confirmed with our finance department on 8/25/11. As of	9/7/11 10/7/11 10/7/11

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F 225	Continued From page 6 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R116 and R110) out of 47 sampled residents, the facility failed to immediately report and thoroughly investigate an allegation of abuse for R116 who reported to staff she was being threatened and an allegation of misappropriation of resident funds for R110 who reported to staff she was missing money. Findings include: The facility's policy and procedure for "Abuse Prevention Plan IV. Scope of Responsibility Employee- Is required to report any suspected act of abuse..." 1. On 8/19/11 R116 told a surveyor that E5 (Public Guardian) threatened her. On 8/19/11 E8 (LPN) confirmed that R116 felt E5 was threatening her. On 8/23/11 at 12:15 PM interview with E7 (RN unit manager) revealed she was aware of the allegation of abuse from an e-mail she received from E5 on 8/18/11. E7 continued to state that she did not report this allegation of abuse to Quality Assurance or to the State agency.	F 225	9/26/11, a second report was received from financial management in which they stated this resident received $40.00 on 6/24/11. On 9/26/11, Quality Assurance reopened this investigation and will forward their summary and findings to DLTCRP for review and determination. **Identifying other residents having the potential to be affected** **Concern #1 and #2** All residents have the potential to be affected by this practice if staff do not report allegations of abuse to Quality Assurance and the State Agency in a timely manner for investigation. **Systemic Response** **Concern #1** In accordance with our State and Federal regulatory requirements, all direct care staff will be in-serviced on the importance of immediately reporting allegations of abuse, neglect, mistreatment, misappropriation of resident property, and financial exploitation to Quality Assurance and/or our State Agency for investigation. 10/7/11 **Concern #2** Staff members that did not report our resident's allegation of abuse will be addressed individually by their supervisor(s). Supervisor(s) will schedule counseling sessions with their employees to remind them about their responsibility and adherence to abuse reporting laws and our PM-46 requirements. 10/7/11 **Monitoring** **Concern #1 and #2** Quality Assurance will continue to complete internal facility investigations following notification from employees about reportable incidents. All PM-46 reports will be logged in our Quality Assurance database and all conclusive investigative reports will be forwarded to DLTCRP Investigative Unit within five days. Ongoing	

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F 225	Continued From page 7 On 8/23/11 at 12:50 PM E6 (Social Worker) stated that R116 came to her office on 8/19/11 and spoke with her concerning this allegation of abuse. E6 confirmed this allegation of abuse was not reported to the facility's Quality Assurance for a thorough investigation or to the State agency. However, E6 sent a e-mail to various people (Social Worker, Guardians, Nursing) documenting the interview with R116. On 8/23/11at 2:20 PM interview with E5 revealed that she met with R116. R116 was upset and yelled and made accusatory statements. E5 e-mailed this incident to various people. On 8/23/11 at 3:20 PM E4 (Quality Assurance Administrator) confirmed she was not notified of R116's allegation of abuse; therefore this allegation of abuse was not investigated or immediately reported to the State agency. The facility failed to thoroughly investigate this allegation of abuse and failed to report it to the State agency. This failure occurred despite the fact that this allegation of abuse was e-mailed to several people allowing for several opportunities for this allegation to go through the proper channels for investigating and notifying the State agency. 2. During the survey process a concern was brought to the surveyor indicating that R110 was missing $10.00. When R110 was questioned she stated that she told the nurse about the missing money about 3 weeks ago. The money was in her basket on top of her TV. She was in the day room when her money disappeared.	F 225		

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F 225	Continued From page 8 On 8/18/11 at approximately 10:30 AM this allegation of misappropriation of resident funds was discussed with E8 (LPN) who stated that R110 was never given money. However, E8 stated she would write up the allegation for investigation. On 8/18/11 at approximately 10:35 AM a phone interview was conducted with E9 (finance personnel). E9 stated that on 6/24/11 R110 was given $40.00. On 8/18/11 at approximately 10:45 AM a telephone interview occurred with E10 (QA RN) who stated she had not received an incident report concerning R110's allegation of missing money. This is a repeat deficiency for this facility it was cited in the following surveys: 4/5/11 during a complaint survey, 2/12/10 annual survey, and 4/8/09 annual survey.	F 225		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations throughout the Candee building during the survey, it was determined that the facility failed to maintain resident furnishings in good repair for seven (R129, R28, R194, R55, R175, R106 and R6) out of 47 sampled residents.	F 253 **Immediate Corrective Action** **Identifying other residents having the potential to be affected**	**F253** **Concerns #1, #2, #3, #4, #5, #6, #7 and #8** Work orders were submitted for all areas and items for replacement and/or repair. All residents have the potential to be affected by work orders not being generated for services necessary to maintain a sanitary, orderly and comfortable interior.	8/26/11

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F 253	Continued From page 9 Findings include: 1. On 8/16/11 at 3:17 PM, the dresser for R129 was missing the front panel to the third drawer from the top. A follow-up observation on 08/23/11 at 11:20 AM revealed identical findings. 2. On 8/16/11 at 2:36 PM, R28 had an out-dated, 1970 ' s style, green vinyl, waiting room chair as her room chair with a semi-patched tear in the seat. This vinyl seat could not be completely cleaned and sanitized due to the tear and repair. A follow-up observation on 08/23/11 at 11:05 AM revealed identical findings. 3. The bed footboard for R194 had scrapes, scuffs, and pieces missing on 8/23/11 at 10:55 AM. 4. On 8/16/11 at 2:52 PM, R55's room had a large green spot on the wall, under the overbed light, where paint was peeling off of the wall and wall damage near the sink was observed. 5. On 8/15/11 at 11:56 AM, R194's room had 2 areas with a large, 8 to 10 inch gouge out of the walls around the bed. 6. On 8/16/11 at 11:52 AM, R175's room was found to have wall scrapes and scratches between the closets next to her bed. 7. On 8/17/11 at 10:10 AM, R106's room had wall scrapes and gouges at the bed headboard area. A follow-up observation on 8/23/11 at 11:03 revealed identical findings. 8. On 8/16/11 at 2:32 PM, R6's room had	F 253 Systemic Response	**Concern #1** The dresser was replaced with a brand new five drawer dresser for R129. **Concern #2** The green vinyl chair in R28's room was replaced with a new chair. **Concern #3** The bed footboard for R194 was replaced with a new footboard. **Concern #4** The large green spot on the wall and the wall damage will be repaired and repainted in the room of R55. **Concern #5** The two areas with a large 8 to 10 inch gouge out of the wall around the bed has been repaired and repainted in the room of R194. **Concern #6** The wall scrapes and scratches between the closets next to R175's bed have been repaired and repainted. **Concern #7** The wall scrapes and gouges at the bed headboard areas of R106's room will be repaired and repainted. **Concern #8** The wall damage about a foot in length under the outlet under the over bed light in R6's room will be repaired and repainted. **Concerns #1, #2, #3, #4, #5, #6, #7 and #8** The facility's Quality Assurance Risk Manager will complete an environmental inspection of all residents' rooms monthly to identify areas that need maintenance or repair. The facility's maintenance work order request system will also be relied on to identify and report areas that need maintenance work, repair and/or replacement.	9/2/11 9/26/11 9/26/11 10/8/11 9/28/11 9/28/11 10/8/11 10/8/11 9/30/11 and ongoing

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F 253	Continued From page 10 wall damage about a foot in length under the outlet, under the overbed light in his room. A follow-up observation on 08/23/11 at 11:07 revealed identical findings.	F 253 **Monitoring**	The facility's Quality Assurance Risk Manager will continue to conduct safety and environmental inspections throughout the facility monthly to identify areas of concern and to ensure that work orders are turned in for corrective action. Risk Manager will also monitor completion of correction plan for these areas. Safety and environmental inspection reports will be turned into Quality Assurance monthly.	9/30/11 and ongoing
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R35, R116, and R29) out of 47 sampled residents the facility failed to develop a care plan based on identified care needs. Findings include: 1. Review of R35's clinical record revealed R35	F 279 **Immediate Corrective Action** **Identifying other residents having the potential to be affected**	**F279** **Concern #1** No significant adverse effects were experienced. **Concern #2** Care plan revised to reflect having a 3rd party present when meeting with resident. **Concern #3** Resident transferred to hospital on 5/8/11 where she expired due to multiple complex medical complications. All residents having a change in need or condition have the potential to be affected by this practice.	9/7/11

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DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

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F 279	Continued From page 11 had diagnoses that included dementia, trigeminal neuralgia mild, cerebral vascular accident, gastroesophageal reflux disease, and Alzheimer. Review of the 6/22/11 dietician's assessment revealed that R35 should be assessed for aspirating when eating. Review of R35's physician order revealed she was ordered a pureed diet with honey thickened liquids. The physician order sheet also stated R35 was on "Aspiration Precautions". On 8/24/11 at approximately 10 AM E7 (RN-Unit Manger) confirmed the facility failed to develop a care plan with interventions for aspiration precautions for R35. 2. Cross refer F225, example 1. On 8/19/11 R116 reported to E6 (Social Worker) that E5 (Legal Guardian) threatened her. On 8/23/11 at 3:20 PM an interview was conducted with E4 (Quality Assurance Administrator) who stated that R116 had accused other staff members of abuse. There had been thorough investigations of these allegations. An allegation of abuse that occurred in June 2011 was investigated by the facility and the State agency. At the conclusion of the investigation in June 2011, it was recommended that staff members should have a third party present when meeting with R116 and not meet with her alone. On 8/24/11 at 10:40 AM review of R116's care plan was done with E7 who confirmed that the facility failed to develop a care plan to address	F 279 **Systemic Response** **Monitoring**	**Concern #1** Policy #1810 (Aspiration Precautions) will be reviewed and revised to reflect ensuring that any resident at risk for aspiration or with swallowing difficulties must be care planned. (See attached policy) Staff will be inserviced on this policy by 10/8/11. **Concern #2** Cross reference F225 – Resident's care plan was updated to reflect DLTCRP's recommendations. **Concerns #1, #2 and #3** P/P 401 (Care Plan Implementation and Review) will be reviewed and revised to emphasize that care plan evaluation is ongoing and revisions should be made as the needs and condition of the resident changes. (See Attached Policy) Nursing staff will be inserviced on this policy by 10/8/11. **Concern #1** Head Nurse or designee and supervisors will review the 24 hour report daily to determine residents placed on aspiration precautions and monitor that they are care planned. **Concerns #1, #2, and #3** Head nurse or charge nurse will also review report daily for any changes in the needs or condition of residents and verify that the changes have been made to the individual care plans. Nursing Supervisors will initial off on each 24 hour report indicating that it has been read and recommendations provided to Head Nurse or designee as needed. Quality Assurance to be provided with a quarterly report from the Nursing Supervisors indicating the 24 hour report findings and recommendations.	9/22/01 10/8/11 9/7/11 9/22/11 10/8/11 10/8/11 and ongoing 10/8/11 and ongoing

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F 279	Continued From page 12 R116's accusations with interventions that included to have a third party present when meeting with R116. 3. Review of "(Facility Name) Infection Reporting Form" dated 4/25/11 for R29 noted a diagnosis of "wound infection" with an elevated white count of 21.4 (normal range of 4-10.5). On 4/25/11, physician's orders included new interventions of vital signs every four hours for 48 hours and Zyvox (medication to treat infections) 600 mg. (milligrams) twice a day for 7 days. Record review lacked evidence of a care plan for this new infection.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280 **Immediate Corrective Action** **Identifying other residents having the potential to be affected** **Systemic Response**	**F280** **Concern #1** Care Plan was corrected immediately to remove the use of plastic utensils. **Concern #2** Resident was sent to the hospital. **Concern #1** All residents having a significant change in their needs or care have the potential to be affected. **Concern #2** All residents that have a diet change have the potential to be affected. **Concern #1** P/P 401 (Care Plan Implementation and Review) will be reviewed and revised to emphasize that care plan evaluation is ongoing and revisions should be made as the needs and condition of the resident changes. (See Attached Policy)	8/18/11 7/22/11 9/22/11

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F 280	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise two (R35 and R32) out of 47sampled residents' care plans to address the changes. Findings include: Review of R35 care plan revealed she was care planned for having plastic, knives, forks and spoons. 1. Review of R35's care plan with E7 (RN Unit Manger) and E8 (LPN) on 8/18/11 at 12:30 PM revealed R35 no longer fed herself and did not need to have plastic utensils for safety reasons. E7 confirmed that the facility failed to review and revise R35's care plan and resident profile to address this change in care needs for R35. E7 immediately made the changes to R35's care plan and resident profile. 2. Cross refer F309, example #1. R32 returned to the facility post hospitalization on 7/20/11. The physician discontinued all previous diet orders and ordered a tube feeding formula around the clock. The physician also removed the "by mouth" order from all the medications and ordered all medication to be given by gastrostomy tube. Review of the care plan on 8/22/11 documented	F 280 Monitoring	Nursing staff will be inserviced on this policy by 10/8/11. **Concern #2** P/P #300 (Admission and Readmission) will be reviewed and revised to emphasize the need to review care plans for readmitted residents to ensure changes in need and condition are reflected on the plan. (See Attached Policy) P/P 401 (Care Plan Implementation and Review) will be reviewed and revised to emphasize that care plan evaluation is ongoing and revisions should be made as the needs and condition of the resident changes. (See Attached Policy) Nursing staff will be inserviced on these policies by 10/8/11. A root cause analysis will be held with Corporate Compliance Officer from Liberty Healthcare Corporation. **Concern #1** Head Nurse or designee will review monthly the continued need for plastic utensils for all residents using same and make revisions to the care plan as needed. **Concern #2** Head Nurse or designee will review readmission documentation to ensure all documentation and changes are accurately care planned. Head nurse or charge nurse will review the 24-hour report daily for any changes in the needs or condition of residents and verify back on the 24-hour report that the changes have been made to the individual care plans. Interdisciplinary Care Committee will review and update residents with order for plastic utensils quarterly.	10/8/11 9/22/01 9/22/01 10/8/11 10/4/11 10/8/11 and ongoing 10/8/11 and ongoing

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F 280	Continued From page 14 that the resident was receiving a pureed snack at lunch time and pudding in the evening. The failure to update the care plan to reflect the NPO (nothing by mouth) status was confirmed with E19 (Unit Manager) on 8/22/11.	F 280	Reports will be forwarded to Quality Assurance for review quarterly. Quality Assurance will also review all readmissions to ensure that they are properly care planned.	10/8/11 and ongoing
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309 **Immediate Corrective Action** **Identifying other residents having the potential to be affected**	**F309** Resident sent to the hospital on 7/22/11 All residents having a significant change in their needs or care have the potential to be affected.	7/22/11
	This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R32) out of 47 sampled residents the facility failed to ensure that a resident whose plan of care was tube feedings was not provided with any food by mouth. R32 was fed a dinner meal on the second day back from a hospitalization for aspiration pneumonia. This resulted in R32 requiring a second hospitalization for aspiration pneumonia. Findings include: R32 was readmitted to the facility on 7/20/11 after a hospitalization for ventilator dependent respiratory failure, pneumonia and thrombocytopenia. The hospital discharge sheet stated that the diet was to be g-tube feeding with Glucerna.	**Systemic Response**	Policies #300 (Admission and Readmission) and #401 (Care Plan Implementation and Review) will be reviewed and revised. (See Attached Policies) Nursing staff will be inserviced on the revised policies by 10/8/11. Physicians will cross through previous orders, write stop and write the new orders upon resident's readmission. Head Nurse or designee will review readmission documentation to ensure all documentation and changes are accurately care planned. A root cause analysis will be held with Corporate Compliance Officer from Liberty Healthcare Corporation.	9/22/11 10/8/11 10/8/11 and ongoing 10/8/11 and ongoing 10/4/11

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F 309	Continued From page 15 The computer generated Physician Order Sheet (POS) on chart of the long term care facility was dated and altered on 7/20/11 at 3 PM by the physician, E23. The changes included crossing out all diet orders and medications by mouth orders. Additionally, the physician ordered a speech therapy consult and an around the clock tube feeding formula. While the physician did not write a NPO (nothing by mouth) order he intentionally crossed off all diet and medication orders that were to be administered by mouth. Review of the Admission Nursing Assessment dated 7/20/11 at 2:15 PM documented the diet as enteral feeding (tube feeding). A nurse ' s note on 7/21/11 at 10:50 PM stated the resident was fed dinner because the aide did not know the resident was not supposed to get anything by mouth (NPO). The resident's vital signs were noted to be stable and the resident was not short of breath. This resulted in the resident being fed dinner while receiving a continuous tube feeding. An interview on 8/23/11 with E21, the aide who fed the resident dinner, revealed that she was not usually assigned to this unit and was not on the unit at the time of the start of shift report. E21 further stated that she was not told the resident was NPO (nothing by mouth) and that a dinner tray came to the floor for the resident. E21 revealed that her assignment sheet noted that she was to feed R32 so she did. The resident tolerated the meal without any problems noted. Review on 8/22/11 of the current assignment	F 309	**Monitoring** Head nurse or charge nurse will review the 24 hour report daily for any changes in the needs or condition of residents and verify back on the 24 hour report that the changes have been made to the individual care plans. Registered Dietitian will continue to review diet orders quarterly on all residents and provide findings to Quality Assurance. Quality Assurance will also review all readmissions to ensure that they are properly care planned.	10/8/11 and ongoing

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F 309	Continued From page 16 sheet for Assignment #3 for the 3-11 PM shift still included the task of feeding R32. A Diet Communication form was initiated by nursing on 7/21/11 at 8:25 AM. The head nurse E19, called the dietary department on 8/22/11 where it was revealed that they did not enter the change into the system until 7/22/11. It was unclear when the dietary department actually received the communication form. Review of the care plan dated 3/26/10 and last reviewed on 6/22/11 revealed that a pureed diet with nectar liquids had been crossed out in pen with no discontinuation date. The approach of a pureed snack at lunch time and pudding in the evening remained on the care plan as of 8/22/11. Review of the Nursing Aide Documentation Sheet (NADS) for July 2011 included the pureed diet with nectar thick liquids for snacks and pudding. The letters NPO were noted on 7/21/11 but 7/20 and 7/22/11 were blank. An interview with E24, a CNA working the 3-11 shift on 7/21/11 revealed that R32 ' s meal consumption for dinner was documented on the unit ' s meal sheet that night and she was aware the E21 had fed R32. The daily meal sheet was not retained by the facility. A nurse ' s note on 7/21/11 at 12 midnight documented that R32 ' s lungs were noted with expiratory wheeze, frequent non productive cough and Robitussin was given with little relief and Tylenol was given for discomfort. Nurses ' notes on 7/22/11 documented that on	F 309		

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F 309	Continued From page 17 day shift R32 continued to have coughing, expiratory wheezing and was sluggish. At 3 PM the resident had decreased oxygen saturation to 81% and was started on oxygen. At 4 PM the resident was in respiratory distress with decreased breath sounds in all lung fields, no air exchange in right lower lobe and inspiratory wheeze in right upper lobe. There was expiratory wheezing bilaterally and a nebulizer treatment was administered with no improvement. The resident was sent to the emergency room. The hospital history and physical dated 7/22/11 documented under assessment aspiration pneumonia and acute respiratory failure. The chest x-ray from the hospital dated 7/22/11 documented worsening left basilar infiltrate (as compared to 4 days earlier) and aspiration pneumonia should be considered. The discharge diagnoses included acute respiratory failure, status post mechanical ventilation and bilateral pneumonia with methicillin-resistant staphylococcus aureus (MRSA). An interview on 8/19/11 at 11 AM with E2, DON and E3, RN Supervisor revealed that they were unaware that R32 was fed a dinner tray when he was NPO and went to the hospital less then 24 hours later in respiratory failure. An interview on 8/24/11 with the QA Administrator, E4 revealed that although nurses in her department review the records of all residents who go to the emergency room or hospital there was no report or investigation of	F 309		

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F 309	Continued From page 18 the resident being fed a dinner tray while NPO.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to maintain acceptable parameters of nutritional status, such as monitoring of body weight and consumption of meals and supplements for one (R29) out of 47 sampled residents. R29 was assessed as high risk for nutrition, however, the facility failed to have a system to monitor and analyze the collection of nutritional data (including but not limited to dry weights, meal and nutritional consumption) and consequently failed to evaluate and implement new interventions. Findings include: R29 was admitted to the facility on 4/14/11 with diagnoses including status post right below the knee amputation, status post cholecystectomy, insulin dependent diabetes mellitus, hypertension, chronic obstructive pulmonary disease,	F 325	**F325** **Immediate Corrective Action** Resident discharged to the hospital due to her complex medical condition and expired. **Identifying other residents having the potential to be affected** All residents on dialysis have the potential to be affected by this practice. All residents on supplements for poor food intake have the potential to be affected. **Systemic Response** Dialysis Communication Form (#07-010) developed 9/21/11 to be sent to dialysis with dialysis residents. First part to be completed by DHCI nurse before sending resident and second part to be completed by dialysis unit before leaving dialysis. Includes weight on form as well as percentage of meal eaten while at dialysis. Form will be sent on each dialysis day. (See Attached Form) Registered Dietitian to ensure upon receipt of monthly dialysis residents' report cards are sent to the appropriate nursing unit for placement in the Physicians' Communication Books for their review. Nursing P/P #544 – Weight and Nutrition was reviewed and revised to reflect that all new admissions (excluding Hospice admissions) will be weighed upon admission and then weekly thereafter times four weeks. (See Attached Policy)	5/8/11 10/8/11 and ongoing 10/8/11 and ongoing 9/26/11

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F 325	Continued From page 19 hypertension, stage IV pressure ulcer (PU) of sacrum, and end stage renal disease (ESRD) and was on hemodialysis three times a week. Admission Minimum Data Set (MDS) assessment dated 4/20/11 documented that R29 was moderately impaired for daily decision making (decisions poor; cues/supervision required), required limited assistance of one staff person for eating, had no swallowing difficulty, and had one stage IV PU. Admission orders dated 4/14/11 included: - Carbohydrate controlled diet with bedtime snack. - Liquid diabetic supplement (Glucerna or Glytrol) 240 cubic centimeters if resident eats less than 50% of meal. - ProSource Zac (supplement specifically formulated to provide the nutrients for the dietary management of non-healing wounds and pressure ulcers that require additional protein) one ounce by mouth three times a day. Care plan implemented on 4/14/11 titled "Nutrition" noted a goal that R29 will have no significant weight change. Approaches included: - Weigh resident every month or as ordered. Follow hospital policy in regard to weight changes. - Meals: Record %. Notify nurse if less than 50%. Regular mechanical soft diet with bedtime snack. - Snacks as ordered. - Hydration rounds. Review of Nurse's Note (N.N.) dated 4/15/11 timed 6:30 AM documented "took time swallowing	F 325	Nursing P/P #406 – Food, Fluid and Snack Intake Record will be reviewed and revised with all Nursing Staff for the importance of recording the percentage of food, fluid and snacks consumed. Nursing staff will be inserviced on the revised policies by 10/8/11. **Monitoring** Dialysis Communication Form will be reviewed by charge nurse upon resident's return from dialysis each dialysis day and placed in the Physicians' Communication Book for their review and then placed in the resident's medical record. Registered Dietitian to provide copy of all dialysis residents' monthly report card to Quality Assurance. Quality Assurance to monitor weights on all new admissions. Head Nurse or designee will review all residents' Nursing Assistant Data Sheets for percentage of food, fluid and snacks consumed and provide data to Quality Assurance on a monthly basis.	9/22/11 10/8/11 10/8/11 and ongoing 10/8/11 and ongoing 10/8/11 and ongoing 10/8/11 and ongoing

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F 325	Continued From page 20	F 325		

R/T (related to) ?." N.N. on the same date timed 5:40 PM documented that R29 verbalized that the "chicken did not taste like the one she used to cook at home."

Review of the initial Nutrition Assessment dated 4/15/11 competed by E25 (Registered Dietician) documented the most recent weight of 138 pounds (#) on admission to the facility on 4/14/11. R29 was assessed as high nutritional risk secondary to ESRD, albumin less than 3.0 g/dl (1.5), 3-5 other nutritional related laboratory results that were within abnormal range, and stage IV sacrum PU. The recommendation by E25 was for a SLP (Speech Language Pathologist) consultation for appropriate intervention if needed due to the above N.N. on 4/15/11 documenting possible swallowing problem. E25's plan was to revisit in one week for food preference. The initials of E27 (attending physician) and a date of 4/20/11 were noted on this assessment, however, record review lacked evidence of an order for a SLP consultation.

An additional N.N.dated 4/16/11 timed 1 PM documented that R29 was holding food in the mouth and refusing to swallow and another N.N. timed 5:40 PM documented that R29 was pocketing and spitting out food. N.N. dated 4/17/11 timed 6 PM documented that R29's family members requested an evaluation pertaining to resident's lack of appetite and refusal to eat meals.

Review of the "Doctor's Book" documented an entry on 4/18/11 that R29's "niece/daughter requested info. (information) regarding not eating." The written response by E27 (attending

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DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21 physician) was "nurse to follow-up patient eating." N.N. dated 4/18/11 timed 11:45 AM documented " put on weekly weight secondary to decreased appetite to monitor possible weight loss." On 4/20/11, E27 ordered weekly weights for four weeks. Review of the facility's policy titled "Weight and Nutrition" indicated that for a dialysis resident, weights from dialysis (i.e. dry weight) will be used for monitoring changes. Review of R29's "graphic sheet" noted only the admission weight of 138# on 4/14/11 which was obtained by utilizing the scale at the facility, thus, not a dry weight. Upon surveyor's inquiry, additional weights were located in a binder in the unit by E26 (Registered Nurse) during the survey. Review of "weekly weights" document noted that weights were obtained on 4/18/11 136.6# and 4/25/11 132# (6# or 2.9% loss), however, the third weekly weight which was to be obtained on 5/2/11 was not documented. In addition, these weights once again were obtained utilizing the facility scale, thus, not a day weight to monitor weight changes. E26 reported to the surveyor that there was no formal method of communication between the dialysis center and the facility, thus, to obtain dry weights, the facility would have had to contact the dialysis center. E26 related that there was no additional weight information available in the records. Although R29 was assessed as high risk for nutrition and on 4/18/11 the facility initiated	F 325		

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F 325	Continued From page 22 obtaining weekly weights "...secondary to decreased appetite to monitor possible weight loss", the facility failed to have a system to ensure that the dry weights were obtained in order to monitor the changes. Review of R29's meal consumption record from 4/15/11 through 4/30/11 (16 days or 48 meals) revealed that R29 consumed one meal greater than 50% on 4/19/11 when R29's family had brought in a dinner meal. The remainder of the meal consumption are as follows: - 16 meals documented as refused. - 15 meals with no documentation. - 3 meals with meal consumption of 50%. - 10 meals with meal consumption varying from 0%-25%. - 3 meals documented as LOA (Leave of absence when R29 was out of the facility at the dialysis center, thus, no percentage was documented). This document also noted that R29 refused snacks eight times and there was no documentation for the remainder of the snacks. Review of the Medication Administration Record (MAR) from 4/15/11 through 4/30/11, which documented the liquid diabetic supplement when R29's meal consumption was less than 50% (44 meals consumed was less than 50%) revealed the following: - 5 refusals. - 21 supplement with no documentation. - 100% supplement taken for 9 administrations; varying from 25%-75% for 9 supplements. Interview with E2 (Director of Nursing/DON) on 8/24/11 at approximately 9:15 AM revealed that in the past, the facility utilized a written form of	F 325		

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F 325	Continued From page 23 communication for care coordination for those residents under hemodialysis, however, this process was no longer being utilized. E2 revealed that the charge nurse was responsible to monitor and analyze R29's nutritional data including meal consumption, supplements, and weights. E2 related that during the month of April 2011, an Interim Unit Manager and Charge Nurse was assigned to the unit where R29 resided. An interview with E32 (Registered Nurse and Interim Unit Manager and Charge Nurse)on 8/29/11 at 12 noon confirmed that she was the interim unit manager and charge nurse for the month of April 2011 and she was responsible for monitoring the meal consumption records in addition to the supplements, however, E32 related that there was no orientation to her new role. E32 recalled that she called the dialysis center to obtain weights, however, E32 was not able to locate the information for the surveyor. E32 reported that R29 enjoyed eating desserts and food items that were sweet such as Glucerna and R29 would eat food brought in by her daughter. Although R29 had evidence of a decreased nutritional consumption including meals and snacks as well as varying supplement intake, record review and interviews lacked evidence that the facility monitored and reassessed the nutritional interventions. Additional review of R29's meal consumption record from 5/1/11 through 5/7/11 (seven days or 21 meals) revealed that R29 consumed 100 % of one meal on 5/5/11 when R29's family had brought in a dinner meal. The remainder of the	F 325		

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F 325	Continued From page 24 meals consumed are as follows: - 11 meals documented as refused. - 7 meals with no documentation. - 3 meals documented as LOA Snacks were documented as refused four times and there was no documentation for the remainder of the snacks. Review of the MAR from 5/1/11 through 5/7/11 documented that R29's supplement consumption increased as noted below: - 1 refusal. - 8 supplement with no documentation. - 9 administration with 100% intake; 3 administration varying between 25%-75%). Although R29's meal and snack consumption in May 2011 remained unchanged and R29's supplement intake improved, record review and interview lacked evidence that the facility monitored, analyzed, and reassessed the interventions. An interview with E25 (Registered Dietician) on 8/18/11 at 2 PM revealed that she does not recall speaking with R29 regarding R29's food preference. However, E25 related that she must have attempted to obtain food preferences since E25 signed and dated the document. E25 confirmed that there was no additional dietician reassessment of R29's nutritional status. An additional interview with E25 on 8/30/11 at 2 PM revealed that if the dietician was consulted, there may have been opportunities to increase oral intake such as increasing the amount and frequency of the supplements. Despite the fact that R29's nutritional	F 325		

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F 325	Continued From page 25	F 325		

consumption continued to decrease, record review and interviews lacked evidence that the facility monitored the resident's weights, meal and nutritional supplements. There was no evidence that the facility had a system to gather and analyze all of R29's weights, such as those in the dialysis centers and those in the facility. Additionally there was no evidence that the facility reassessed the interventions implemented for R 29.

After the survey and before the completion of this report the facility provided the surveyor with the following weights from the dialysis centers which the facility failed to obtain when R29 resided at the facility.
- 4/13/11: 128.04 # (one day prior to admission to the facility)
- 4/15/11: 135.8#
- 4/21/11: 132 #
- 4/23/11: 134.64#
- 4/26/11: 134.2#
- 4/28/11: 129.58#
- 4/30/11: 131.56#
- 5/2/11: 128.48#
- 5/4/11: 128.48#
- 5/6/11: 128.48#

It is unclear why these weights differ from those initially gathered by the surveyor.

On 8/29/11, the surveyor received an written communication from E27 (Doctor) that "the patient would not eat the (name of facility) food for her daughter. The diet restrictions were the standard renal, carb control that we use for the diabetic/dialysis patients."

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F 325	Continued From page 26 On 8/30/11, E29 forwarded a communication which included weights obtained at the facility (non dry weight or post dialysis weight) and additional weights (dry weight) from the dialysis centers. E29 related that with weights obtained at different settings including different scales, it would have been difficult to accurately determine weight loss. While it may have been difficult to accurately determine weight loss there is no evidence that when R29 had a decreased nutritional consumption including meals, snacks and supplements, record review and interviews failed to provide evidence that the facility had a system in place to monitor R29's weights and consequently failed to monitor and reassess the nutritional interventions.	F 325		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	**F329** **Immediate Corrective Action** Resident sent to hospital 4/24/11 with Dilantin toxicity. **Identifying other residents having the potential to be affected** Any resident having labs done has the potential to be affected by this practice. **Systemic Response** Tracking system for labs will be reviewed and revised as needed. Tracking system will be inserviced to nurses and nursing unit operation support specialists (OSS) by 10/8/11. (See Attached Memo)	4/24/11 927/11 10/8/11

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F 329	Continued From page 27 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (206) out of 47 sampled residents the facility failed to monitor therapeutic drug levels of a resident on the anti-seizure medication, Dilantin (anitepileptic/anitseizure). This resulted in the resident being hospitalized and treated for encephalopathy and Dilantin toxicity. Findings include: R206 was admitted on 3/15/11 from another long term care facility. Diagnoses included subarachnoid hemorrhage with evacuation and residual dense left hemi hemiparesis, hypertension (HTN), seizure disorder, diabetes, polysubstance abuse, depression, degenerative joint disease, anemia, and reflux. Physician admission orders included Dilantin (seizure medication) 150 mg at 8:30 AM and 12:30 AM and 300 mg at 4:30 PM. The resident ' s care plan dated 3/15/11 for potential for injury related to seizure disorder included the approach assess effectiveness of medication by monitoring seizure activity and drug levels.	F 329	Lab policy and procedure (Unit 6 from the Infection Control Manual) will be reviewed and inserviced to nurses and nursing unit operation support specialists by 10/8/11. A root cause analysis will be held with Corporate Compliance Officer from Liberty Healthcare Corporation. **Monitoring** OSS, charge nurse or designee will monitor the lab tracking sheets daily to ensure all lab results are available and printed in a timely manner. Quality Assurance to review Nursing Units' Lab Tracking Notebooks monthly.	10/8/11 10/4/11 10/8/11 and ongoing

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F 329	Continued From page 28 Dilantin levels were recorded as follows; 3/9/11 12.2 ug/ml (normal 10.0 - 20.0 ug/ml) done at previous facility 3/16/11 18.4 MD signed same day. 3/24/11 18.1 MD signed 3/25/11 A MD order dated 3/17/11 stated Dilantin level in one week then in two weeks diagnosis seizures. The Dilantin level on 4/7/11 was 20.4 and noted to be " High " . This was signed on 4/25/11 by the MD with a note that the Dilantin level came to him very late. Laboratory results for 4/7/11 indicated the blood was obtained at 4:55 AM and results were sent to the facility at 2:06 PM. An interview on 8/18/11 with E17 (unit clerk) and E18 (RN) revealed the facility's process for laboratory tests was to put the laboratory request in the lab book. The lab comes in early in the morning and takes out the slips and draws the ordered blood work. The laboratory results are returned to the facility via a laboratory printer on the unit. The nursing staff is also able to log onto the lab ' s website and print out laboratory results. The laboratory results are then flagged for the physician to review and then filed in the clinical record. Any laboratory result that is considered critical would be called to the facility and faxed to the nursing supervisor as well. There was however no check and balance system to track the laboratory results as they came into the facility to ensure results were returned to the facility and the physician was notified as appropriate.	F 329		

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F 329	Continued From page 29 The facility's laboratory policy and procedure included leaving a copy of the lab slip in the lab book until the results had been reviewed by the physician. The policy also included instructions for unit clerk and charge nurse to print the laboratory results form the electronic lab system and to not remove the copy in the lab book until the final lab results were reviewed by the physician. A nurse ' s note dated 4/24/11 documented the nurse was called to resident's room @ 9:05 AM by a CNA. R206 was found unresponsive. Vital signs were blood pressure (BP) 98/70, temperature 98.6, pulse 68, respirations14, blood sugar BS 118 and pulse ox 98%. The resident was sent to the hospital via 911 services. A corresponding telephone order indicated the resident was unresponsive and was to be transported to hospital. A physician progress note dated 4/29/11 documented R206 was treated at the hospital for Dilantin toxicity of 35.9 with encephalopathy and bronchitis. However physician progress notes written on 4/13, 4/14, 4/20 and 4/24/11 did not mention the Dilantin level that was ordered 3/17/11 and obtained on 4/7/11. An interview on 8/19/11 with the attending physician E16 revealed he did not know why he did not receive the 4/7/11 Dilantin results. E16 was also uncertain why the Dilantin level was so high but stated it may have been the result of a drug reaction. It was revealed that the 4/7/11 Dilantin level was found after the resident went out to the hospital on 4/24/11.	F 329		

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F 329	Continued From page 30 An interview on 8/19/11 with the DON E2 and one of the day shift nursing supervisors, E3 revealed that they were not aware that R206 had an elevated Dilantin level that was never monitored or reviewed by the physician or nursing staff. An interview on 8/24/11 with the QA Administrator, E4 revealed that although nurses in her department review the records of all residents who go to the emergency room or hospital there was no report or investigation of the missing laboratory results and subsequent hospitalization for Dilantin toxicity. The initial hospital assessment documented encephalopathy, most likely secondary to Dilantin toxicity and elevated Dilantin level (35.9), most likely Dilantin toxicity. Review of the hospital discharge documents for 4/29/11 revealed the final diagnoses were encephalopathy, seizure disorder, hypertension, mild dementia, diabetes and bronchitis. Under laboratory findings it was documented that the Serum Dilantin level on hospital admission on 4/24/11 was 35.9, which later came down to 12.4.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	**Immediate Corrective Action** **F334** **Concerns #1, #2 and #3** Infection Control Preventionist sent email on 9/9/11 to all head nurses regarding the importance of documenting vaccine refusals by the resident or responsible party.	9/9/11

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F 334	Continued From page 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of	F 334	Email also sent to head nurses and the nursing unit operation support specialists by Infection Control Preventionist on 9/8/11 informing them of the new location of the educational component of the vaccines and to make sure the resident and/or responsible party has reviewed the CDC's Vaccine Information Statement prior to signing the consent form. Resident 202 had refused the flu vaccine when offered, however did receive it on 1/4/11 which was within the influenza vaccination window of October through April. **Identifying other residents having the potential to be affected** **Concerns #1, #2 and #3** All residents have the potential to be affected by this practice. **Systemic Response** **Concerns #1, #2 and #3** Nursing Department developed tracking system which will display specific dates of mailings, returns, second mailings (if needed) and date the Head Nurse of resident's unit was contacted to begin verbal consent process with resident and/or responsible party, if needed. All mailings will be sent and tracked by Nursing Department and all mailings will contain a self-addressed, stamped envelope for return. The Infection Control Preventionist developed a new consent form titled "Immunization Consent Form For Residents" on 9/8/11 which provides an educational component for each vaccine.	9/8/11 1/4/11 9/8/11 and ongoing 9/8/11 and ongoing

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F 334	Continued From page 32 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that the facility's influenza and pneumococcal immunization policies failed to include an educational component. In addition, two (R202 and R168) out of five sampled residents lacked evidence that they were offered the influenza immunization. Findings include: 1a. Review of the facility's policy and procedure titled "Influenza Prevention Program, Annual" failed to include the educational component as it related to the benefits and the potential side effects of receiving the immunization. 1b. Review of the facility's "Pneumococcal Vaccine Algorithm" provided to the surveyor as the facility's policy and procedure for pneumococcal immunization failed to include the educational component as it related to the	F 334 **Monitoring**	Nursing staff will be inserviced on informed consent guidelines and new tracking system. **Concerns #1, #2 and #3** The return of the consent forms will be monitored by the Infection Control Preventionist or designee and provided to Quality Assurance on an annual basis.	10/8/11 10/8/11 and ongoing

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F 334	Continued From page 33 benefits and the potential side effects of the immunization. 2. R202 was admitted to the facility on 9/9/10. Record review revealed that R202 refused the influenza immunization on 1/4/11, approximately four months after admission. Interview with E37 (Infection Control Coordinator) on 8/18/11 at approximately 10 AM revealed that there was no evidence that the immunization was offered prior to 1/4/11. 3. R168 was originally admitted to the facility on 10/8/08. Record review lacked evidence that the influenza vaccination was offered during the 2010-2011influenza season. An interview with E37 on 8/18/11 at approximately 10:15 AM revealed that the consent should have been sent by the social services department to R168's responsible party, however, the facility had no evidence that this was completed. Repeat deficiency from annual survey ending 4/8/2009.	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441 **Immediate Corrective Action**	**F441** **Concerns #1 and #2** Due to not being informed at the time of infraction of nurse involved no immediate corrective action was able to be performed. However, after receipt of the annual and complaint survey and listing of participating employees, the respective nurses involved were re-educated on the proper procedures, products and disinfectants that were to be used when using glucometers and /or administrating insulin.	9/15/11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures it was determined that the facility failed to prevent the transmission of disease and infection to residents in the facility. The facility failed to ensure that staff disinfected the glucometer in between resident use. Additionally the facility failed to ensure that staff donned gloves when administering a subcutaneous injection to R30. Findings include:	F 441		
		Identifying other residents having the potential to be affected	**Concerns #1 and #2** All residents who receive finger sticks and/or insulin have the potential to be affected by this practice.	
		Systemic Response	**Concerns #1 and #2** P/P #1400 (FSBS: Tracking, Obtaining and Testing Blood for Glucose) and P/P #1718 (Insulin Administration) will be reviewed and revised to emphasize the need to disinfect the meter between resident uses and the need to wear gloves when administering insulin. (See Attached Policies)	9/22/11
			Nursing staff will be inserviced on these policies by 10/8/11.	10/8/11
		Monitoring	**Concerns #1 and #2** Random audits will be reviewed by the nursing supervisors and head nurses. Nurse will be re-educated immediately if deficient practice is found. Nursing supervisors to send audit results to Quality Assurance monthly.	10/8/11 and ongoing

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F 441	Continued From page 35 1. During medication observation on 8/18/11 at approximately 11:30 AM, E31 (Licensed Practical Nurse) used the glucometer to obtain blood from R90. After using the glucometer, E31 used an alcohol wipe to clean the glucometer and proceeded to use the glucometer to test another resident's blood (R225). An interview with E31 revealed that she cleaned the glucometer with the alcohol wipe. Review of the policy titled "Assure Pro Blood Glucose Meter Quality Checks, Care and Maintenance of" indicated that an EPA registered wipe will be used to clean the outside of the glucometer between each resident test. An interview with E2 (DON) on 8/24/11 at approximately 11 AM revealed that an alcohol wipe is not an EPA registered wipe, thus, the facility failed to disinfect the glucometer as per the facility's policy. 2. During a medication observation on 8/16/11 at 9:25 AM,, E33 (Registered Nurse) administered subcutaneous injection to R30's right upper arm without donning on a pair of gloves. Review of the policy titled "Insulin Administration" indicated that the staff must use "Standard Precaution." An interview with E34 (RN) on 8/16/11 at approximately 11 AM revealed that the staff must don gloves per Standard Precaution when administering injection.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469		

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F 469	Continued From page 36 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations throughout the Candee building during the survey, it was determined that the facility failed to maintain an effective pest control program to keep the facility pest free. Findings include: 1. On 8/16/11 at 2:52 PM, R55 was eating lunch in his room with a fly present in the room with the door to the room closed. 2. On 8/16/11 at 2:52 PM, there was a fly around the Candee 1 nurses station. 3. On 8/16/11 at 11:52 AM, 3 small black ants were observed under the sink in room 304C. 4. On 8/17/11 at 10:07 AM, 2 flies were buzzing around and landing on R60 in the hallway near room 418 during an interview. 5. On 8/23/11 at 11:12 AM, 1 fly was observed in the hallway near the Candee 5 day room. During the survey it was observed in the Candee building that the air curtain was not being utilized and the bug light was not plugged in. Review of the pest control contract revealed that the contract did include flies.	F 469	**F469** **Immediate Corrective Action** A sweep was performed throughout the facility to ensure all air curtains and bug zappers were plugged in and in working condition. Upon receipt of resident identifiers for cited areas of concern work orders were generated for the exterminator. **Identifying other residents having the potential to be affected** All residents have the potential to be affected by this practice. **Systemic Response** The facility's Quality Assurance Risk Manager will complete an environmental inspection of the facility monthly to identify areas in need extermination. The facility's maintenance work order request system will also be relied on to identify and report areas that need extermination and provide exterminator with work orders. **Monitoring** The facility's Quality Assurance Risk Manager will continue to conduct safety and environmental inspections throughout the facility monthly to identify areas of concern and to ensure that work orders are turned in for corrective action. Risk Manager will also monitor completion of correction plan for these areas. Safety and environmental inspection reports will be turned into Quality Assurance monthly.	9/22/11 9/23/11 9/29/11 and ongoing 9/29/11 and ongoing
F 490	483.75 EFFECTIVE	F 490		

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F 490 SS=E	Continued From page 37 ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical and psycho-social well-being of each resident. For three (3)(R206,R32,R116) of 47 residents reviewed this resulted in ineffective and inefficient use of nursing, social service and quality assurance resources. Findings include: 1. Cross refer F329 example 1. An interview on 8/24/11 with E4, the quality assurance administrator (QAA) revealed that her department reviews the records of all residents who have an emergency room visit or a hospital stay. An interview with E17 (unit clerk) and E18 (RN) and review of facility policy revealed that the facility had a system in place to track laboratory services from the initial order from the physician through physician notification of the results. R206 was hospitalized on 4/24/11 after being found unresponsive and was diagnosed with	F 490 **Immediate Corrective Action** **Identifying other residents having the potential to be affected**	**F490** **Concern #1** Resident was sent to the hospital on 4/24/11. **Concern #2** Resident was sent to the hospital on 7/22/11. **Concern #3** On 6/14/11, Quality Assurance submitted an emotional abuse allegation report to DLTCRP Investigative Unit regarding R116 and E5 and this case was found to be unsubstantiated. During the annual survey, on 8/23/11, R116 informed the surveyor about another complaint she reported to E7 on 8/18/11 that was not reported to Quality Assurance or the State Agency for investigation. As of 9/7/11, this allegation of abuse was investigated by Quality Assurance and our investigative findings and summary were reported to DLTCRP Investigative Unit for review and final determination. Staff members that did not report our resident's allegation of abuse will be addressed individually by their supervisor(s). Supervisor(s) will schedule counseling sessions with their employees to remind them about their responsibility and adherence to abuse reporting laws and our PM-46 requirements. **Concern #1** Any resident having labs done has the potential to be affected by this practice.	4/24/11 7/22/11 9/7/11 10/7/11

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F 490	Continued From page 38 Dilantin toxicity. The clinical record clearly documented in the physician progress notes and on the 4/7/11 laboratory results that the elevated Dilantin level received by the facility on 4/7/11 was never reviewed by the physician until 4/25/11. The physician tracked down the results after he found out about the hospitalization for drug toxicity. Although multiple staff members were aware of the missing laboratory data after the resident was hospitalized the administrator, the director of nursing and QAA were not aware until notified by the surveyor. This resulted in the ineffective use of nursing and quality assurance (QA) staff to identify system problems to prevent similar occurrences from happening again. 2. Cross refer F309 example 1. An interview on 8/24/11 with E4, the quality assurance administrator (QAA) revealed that her department reviews the records of all residents who have an emergency room visit or a hospital stay. Review of R32's clinical record documented in the nursing notes that he was fed dinner on 7/21/11 while on a physician ordered continuous tube feeding and physician orders for formula and medications via g-tube only. The resident was hospitalized the next day for aspiration pneumonia. Although interviews revealed that multiple staff members were aware R32 was fed a meal while	F 490 Systemic Response	**Concern #2** Any resident having a change in need or condition has the potential to be affected by this practice. **Concern #3** Any resident having and/or making a complaint of abuse has potential to be affected by this practice. **Concern #1** Tracking system for labs will be reviewed and revised as needed. Tracking system will be inserviced to nurses and OSSs by 10/8/11. **Concern #2** P/P #300 (Admission and Readmission) will be reviewed and revised to emphasize the need to review care plans for readmitted residents to ensure changes in need and condition are reflected on the plan. (See Attached Policy) P/P 401 (Care Plan Implementation and Review) will be reviewed and revised to emphasize that care plan evaluation is ongoing and revisions should be made as the needs and condition of the resident changes. (See Attached Policy) Nursing staff will be inserviced on these policies by 10/8/11. **Concern #3** In accordance with our State and Federal regulatory requirements, all direct care staff will be in-serviced on the importance of immediately reporting allegations of abuse, neglect, mistreatment, misappropriation of resident property, and financial exploitation to Quality Assurance and/or our State Agency for investigation.	9/2711 10/8/11 9/22/11 9/22/11 10/8/11 10/7/11

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F 490	Continued From page 39 NPO the Administrator, DON and QAA were not aware until notified by the surveyor. This resulted in the ineffective use of nursing and QA staff to identify other system failures including the delay in dietary notification of a diet change, the failure to update the aide assignment sheet and care plan, and the failure to properly orient an aide to a new assignment. 3. Cross refer F225 example 1. R116 made an allegation that E5 (legal guardian)was verbally abusive to her. Interviews on 8/23/11 revealed the nurse manager E7 and social worker E6 were both aware of this incident. Interview also revealed that E5 was aware of the accusation against her. Facility administration and QA were never alerted of the abuse allegation resulting in the ineffective use of resources to investigate the allegation and protect the resident.	F 490	**Monitoring** **Concern #1** OSS, charge nurse or designee will monitor the lab tracking sheets daily to ensure all lab results are available and printed in a timely manner. **Concerns #1 and #2** Head nurse or charge nurse will also review report daily for any changes in the needs or condition of residents and verify that the changes have been made to the individual care plans. Nursing Supervisors will initial off on each 24 hour report indicating that it has been read and recommendations provided to Head Nurse or designee as needed. Quality Assurance to be provided with a quarterly report from the Nursing Supervisors indicating the 24 hour report findings and recommendations. **Concern #3** Quality Assurance will continue to complete internal facility investigations following notification from employees about reportable incidents. All PM-46 reports will be logged in our Quality Assurance database and all conclusive investigative reports will be forwarded to DLTCRP Investigative Unit within five days.	10/8/11 and ongoing 10/8/11 and ongoing Ongoing
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R212) out of 47 sampled residents, the facility failed to ensure blood work ordered to assess a resident's health status was obtained. Findings include:	F 502	**Immediate Corrective Action** **F502** Resident was sent to the hospital for precautionary issues for an unrelated medical issue on 8/5/11. **Identifying other residents having the potential to be affected** All residents with ordered labs have the potential to be affected. **Systemic Response** Upon review of this deficiency it was determined that the CBC had been ordered but not recorded on the lab requisition form.	8/5/11 9/22/11

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F 502	Continued From page 40 R212 was originally admitted to the facility on 7/12/11 with diagnoses including cirrhosis, hepatic encephalopathy, anemia, chronic hypothermia, chronic kidney disease, end stage cirrhosis of the liver, morbid obesity, panhypopituitarism, and diabetes mellitus. Most recent hemoglobin result dated 5/25/11 was 9.7 (normal range between 11.7-15.7 g/dl). Review of new admission physician's orders dated 7/12/11 included CBC (complete blood count)with differential and platelets "now and every three months." In addition, R212 was ordered Ferrous Sulfate 325 mg. (milligram) by mouth twice a day for diagnosis of anemia. Record review lacked evidence that the above laboratory service was completed. Interview with E7 (Registered Nurse, Unit Manager) on 8/22/11 at 1:30 PM revealed that there was an oversight and that the above laboratory services were not completed as ordered. On 8/5/11, the resident was sent to the hospital emergency room to rule out a fracture and was noted to have a low hemoglobin of 6.9. Repeat deficiency from annual survey ending 4/8/2009.	F 502	All nurses and nursing unit operation support specialists will be re-educated on the Section I, entitled "Redlining Orders", of the Nursing P/P #1703 entitled "Physician's Orders: Writing, transcribing, checking and redlining". Identified employees involved have been re-educated on the Section I, entitled "Redlining Orders", of the Nursing P/P #1703 entitled "Physician's Orders: Writing, transcribing, checking and redlining". **Monitoring** OSS, charge nurse or designee will monitor the lab tracking sheets daily to ensure all lab results are available and printed in a timely manner. Quality Assurance to review all admission/re-admission to ensure that all physician's orders are followed.	10/8/11 9/28/11 10/8/11 and ongoing
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 41 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R32 and R29) out of 47 residents the facility failed to ensure clinical records were complete and accurately documented. Findings include: 1. Cross refer F309, example #1. R32 was re-admitted to the facility on 7/20/11 after a hospital admission for aspiration pneumonia. The hospital discharge instructions and facility physician orders were for tube feeding only. Review of the Nurses Aides Documentation Sheets for July 2011 revealed pureed snacks and pudding was still an active field on the record. Review of the aide assignment sheet in place on 8/22/11 documented that R32 was to be fed by the aide with assignment #3. The same assignment sheet was in place on the night of 7/21/11 when a dinner tray arrived to the floor and was fed to the resident by the assigned aide. The	F 514	**F514** **Immediate Corrective Action** **Concern #1** Resident returned to facility on 8/8/11 with NPO status. Resident went back to acute care on 8/15/11 and has subsequently been transferred to another LTC facility due to complex respiratory status. **Concern #2** Resident sent to hospital 5/8/11 due to complex medical condition. **Identifying other residents having the potential to be affected** **Concern #1** Any resident having a change in need or condition has the potential to be affected by this practice. **Concern #2** All residents consuming meals at dialysis have the potential to be affected by this practice. All residents on supplements for poor food intake have the potential to be affected. **Systemic Response** **Concern #1** P/P #300 (Admission and Readmission) will be reviewed and revised to emphasize the need to review care plans for readmitted residents to ensure changes in need and condition are reflected on the plan. (See Attached Policy) P/P 401 (Care Plan Implementation and Review) will be reviewed and revised to emphasize that care plan evaluation is ongoing and revisions should be made as the needs and condition of the resident changes. (See Attached Policy)	8/15/11 5/8/11 9/22/11 9/22/11

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F 514	Continued From page 42 resident was NPO on 7/21/11. This was confirmed by interview with the head nurse (E19) on 8/22/11. 2. Cross refer F325. R29 was nutritionally assessed as high risk secondary to end stage renal disease, albumin less than 3.0 g/dl, (3-5 normal), resident at 1.5, other nutritional related laboratory results that were within abnormal range, and stage IV sacrum pressure ulcer. Review of R29's meal consumption record from 4/15/11 through 4/30/11 (16 days or 48 meals) revealed that there was no documentation for 15 meals and three meals were noted as LOA (Leave of absence when R29 was out of the facility at the dialysis center, thus, no percentage was documented). This document also noted that R29 refused snacks eight times and there was no documentation for the remainder of the snacks. Review of the Medication Administration Record (MAR) from 4/15/11 through 4/30/11, which documented that the liquid diabetic supplement when R29's meal consumption was less than 50% (44 meals consumed were less than 50%) revealed that there was no documentation for 20 opportunities to administer the supplement. Additional review of R29's meal consumption record from 5/1/11 through 5/7/11 (seven days or 21 meals) revealed that R29 consumed 100 % of one meal on 5/5/11 when R29's family had	F 514 Monitoring	Nursing staff will be inserviced on these policies by 10/8/11. **Concern #2** A daily Dialysis Communication Form (#07-010) was developed 9/22/11. This will be sent to dialysis for dialysis personnel to record percentage of resident's meal eaten while at dialysis. (See Attached Form) Policy #406 (Food, Fluid and Snack Intake Record) will be reviewed and inserviced to staff by 10/8/11. Policy #911 ((Supplement (Nutritional) Documentation)) will be reviewed and revised and inserviced to staff by 10/8/11. (See Attached Policy) Nursing staff will be inserviced on these policies by 10/8/11. **Concern #1** Head Nurse or designee will review readmission documentation to ensure all documentation and changes are accurately care planned for. Head nurse or charge nurse will review the 24-hour report daily for any changes in the needs or condition of residents and verify that the changes have been made to the individual care plans. Quality Assurance to review all admissions/re-admissions to ensure that all physician's orders are followed. **Concern #2** Dialysis Communication Form will be reviewed for meal intake by charge nurse upon resident's return from dialysis each dialysis day. Random audits will be conducted by the Head Nurse, supervisor and QA to monitor meal, snack and supplement documentation.	10/8/11 9/22/11 and ongoing 10/8/11 9/22/11 10/8/11 10/8/11 and ongoing 10/8/11 and ongoing

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F 514	Continued From page 43 brought in a dinner meal. The remainder of the meal consumptions were 11 refused, 7 with no documentation, and 3 meals documented as LOA Snacks were documented as refused four times and there was no documentation for the remainder of the snacks. . Review of the MAR from 5/1/11 through 5/7/11 documented that the liquid diabetic supplement when R29's meal consumption was less than 50% (20 meals consumed were less than 50%) revealed that there was no documentation for 8 opportunities to administer the supplement. Interview with E2 (Director of Nursing/DON) on 8/24/11 at approximately 9:15 AM revealed that the charge nurse was responsible to ensure complete and accurate documentation.	F 514		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085035	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/24/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 160	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was determined that the facility failed to ensure personal funds were conveyed within 30 days of the death of a resident. Findings include:

1. R34 expired on 7/8/11. Review of the personal funds statement printed 8/18/11 revealed the resident still had $124.19. A notation by the balance indicated staff were waiting to post the July2011 bank interest.

2. R124 expired on 6/2/11. Review of the personal funds statement printed on 8/18/11 revealed $310.67. A notation by the balance indicated staff were waiting to post the July2011 bank interest.

An interview on 8/24/11 at 1:13 PM with E22 (Financial Office staff) revealed that the June 2011 interest was not posted until the first week of August2011 and the July 2011 interest should be post the third week of August, then, the facility can convey the funds

The accounts for residents R34 and R124 were closed on 8/30/11.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital for the Chronically Ill **DATE SURVEY COMPLETED:** August 24, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and compliant visit was conducted at this facility from August 15, 2011 through August 24, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 203. The stage 2 sample was 47 residents.	
3201	**Regulation for Skilled and Intermediate Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey report date completed 8/24/11, F157, F164, F225, F253, F279, F280, F309, F325, F329,	**3201.1.2** Cross referenced CMS 2567-L Tags F157, F164, F225, F253, F279, F280, F309, F325, F329, F334, F441, F469, F490, F502 and F514

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	F334, F441, F469, F490, F502 and F514.			
3201.6.2	**Financial Services**			
3201.6.2.3	**Upon the death of a resident, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that the facility failed to ensure personal funds were conveyed within 30 days of the death of a resident. Findings include: 1. R34 expired on 7/8/11. Review of the personal funds statement printed 8/18/11 revealed the resident still had $124.19. A notation by the balance indicated staff were waiting to post the July 2011 bank interest. 2. R124 expired on 6/2/11. Review of the personal funds statement printed on 8/18/11 revealed $310.67. A notation by the balance indicated staff were waiting to post the July 2011 bank interest. An interview on 8/24/11 at 1:13 PM with E22 (Financial Office staff) revealed that the June 2011 interest was not posted until the first week of August 2011 and the July 2011 interest should be post the third week of August, then, the facility can convey the funds.	**3201.6.2.3**		
		Immediate Corrective Action	The accounts for residents R34 and R124 were closed on 8/30/11.	8/30/11
		Identifying other residents having the potential to be affected	All facility residents have potential to be affected.	
		Systemic Response	Interest to be posted to all residents' accounts once information is received from financial institution. All expired residents' accounts are to be closed within 30 days of death. If interest information is received after closing of the account any interest due to deceased client/estate will be disbursed at that time. The facility Financial Determinations' Officer is to ensure that this process is followed and submit monthly audit to Senior Fiscal Administrative Officer.	8/30/11 and ongoing
		Monitoring	Audits will be submitted monthly to the Facility Senior Fiscal Administrative Officer.	8/30/11 and ongoing

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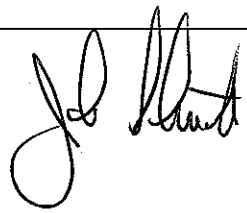

Director

9/29/11